

FOND DU LAC COUNTY HEALTH DEPARTMENT

160 S MACY ST

FOND DU LAC WI, 54935

(920)929-3085



**Authorization To Receive 2009 H1N1 Live Attenuated Influenza Vaccine (Flumist) or
2009 H1N1 Inactivated influenza Vaccine (Injectable)**

Information collected on this form will be used to document authorization for receipt of 2009 H1N1 influenza vaccine at your child's school. Information may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with your child.

Child's Name (Last, First, Middle Initial)		Mother's Maiden Name (Last, First, Middle Initial)			
Address	P. O. Box	City	County	State	Zip Code
Home Telephone Number ()		Date of Birth (mm/dd/yyyy)		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	
Race (Check one) <input type="checkbox"/> African American <input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Pacific <input type="checkbox"/> White <input type="checkbox"/> Other				Ethnicity (Check one) <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino	
Name of Physician		Name of School		Grade	
Name of Parent or Guardian Responsible for Child (Last, First, Middle Initial)				Relationship to child	
Okay to share immunization data with Wisconsin Immunization Registry (WIR)? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Please answer the following questions so we can determine if your child can receive the 2009 H1N1 influenza vaccine and which vaccine is the best for your child. (Injectable vs Intranasal Flumist)

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does your child have a serious allergy to eggs? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does your child have any other serious allergies? Please list: _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has your child ever had a serious reaction to a previous dose of flu vaccine? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has your child ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness)? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Has your child been vaccinated with any vaccine (not just flu) within the past 30 days?
If yes what vaccine _____ Date received: ____/____/____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does your child have any of the following chronic medical conditions such as asthma, diabetes heart, lung or kidney diseases? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does your child have a weak immune system (being treated for cancer, HIV or taking steroid medication)? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Is your child pregnant? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Does your child have close contact with a person who needs care in a protected environment (someone who has recently had a bone marrow transplant)? |

I have read, or have had explained to me the 2009-2010 Vaccine Information statement for 2009 H1N1 influenza vaccine. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine be given to me or to the person named above for whom I am authorized to make this request by the Fond du Lac County Health Department. This consent authorizes the second dose of influenza vaccine if my child is 9 years of age or younger. Consent can be revoked by notifying the Fond du Lac County Health Department @ (920)929-3085.

SIGNATURE - Person to receive vaccine or person authorized to sign on the child's behalf.

Date Signed

X

FOR OFFICE USE ONLY:

2010 H1N1 VACCINE:

DOSE #1:

Route= IM site (circle one): RD or LD IN Dose (circle one) 1 or 2

Manufacturer _____ Lot No. _____ VIS date:10/02/009

Signature and title of person administering vaccine: _____

Date vaccine administered: ____/____/____

Clinic Site: _____

DOSE #2: (Necessary for children 9 years of age or younger)

Route= IM site (circle one): RD or LD IN Dose (circle one) 1 or 2

Manufacturer _____ Lot No. _____ VIS date:10/02/009

Signature and title of person administering vaccine: _____

Date vaccine administered: ____/____/____

Clinic Site: _____